Mathews (Jos. M.)

REPORT ON

DISEASES OF THE RECTUM

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Report on Diseases of the Rectum.

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As your Committee on Diseases of the Rectum, I desire to report on four subjects which pertain to that special line of study, viz:

1. Operations for cancer of the rectum.
2. Operations on the rectum under whisky.
3. The sphincter muscles in disease.
4. A new operation for fistula in ano.

Before detailing the two cases of cancer operated on, I wish to state as succinctly as possible, some views and observations which an experience of some years has taught me.

1. I do not believe that cancer is hereditary; hence its appearance in families, as by family history, is, in my opinion, purely by chance.

2. In my experience scirrhus cancer has been the form most often met with in the rectum, and not epithelioma, as taught by the authorities.

3. I do not believe that colotomy is justifiable for cancer of the rectum.

4. In the observation, which covers many cases of cancer of the rectum, the disease has occurred, in a majority of patients, under the age of forty years; in two instances under twenty.

5. In the majority of cases observed by me the symptoms recited by authors as being characteristic, if not pathognomonic of cancer, were absent, viz.: excessive pain, hemorrhage, and odor.

6. I do not believe that the "facial expression" of the patient, which is dwelt upon with so much stress by authors, ever exists, save as the result of fear and anxiety about their condition.

7. If the cachexia of cancer exists, I do not believe that life is ever prolonged by any operation, except it be to overcome obstruction in the bowel.

8. In cases of cancer beyond all cure, I believe that we are justified in giving sufficient opium to quiet pain, if pain exists, even at the risk of establishing the opium habit.

With these observations you will permit me to recite the operations upon two cases of cancer by two different methods.

CANCER OF THE RECTUM.

Case 1. Mr. B. consulted me, in company with his family physician, and gave the following history: Had complained for six months or more with burning pain at defecation, which radiated up the back and down the thighs. Had for some time a morning diarrhea, accompanied by a mucopurulent discharge. Upon examination a hard growth was detected, situated dorsally, but inclined to the left side, above the internal sphincter muscle about one and a half inches, in size as large as a silver half dollar. No stricture was apparent. The growth was denuded of mucous membrane; was not movable. From it the discharge mentioned came. The rest of the gut was healthy. I suggested to the physician that the growth be removed. He agreed, and the patient was put under chloroform, and we practiced the operation, so well thought of by the Germans, of scraping or scooping out the growth. Having divulsed the sphincter, and the parts being held apart by retractors, I took a lithotomy scoop and persistently scraped away all of the tumor,

and only ceased when it was evident that healthy tissue had been reached. Hemorrhage, which was not excessive at any time, was easily controlled by pressure, no vessels being tied. The wound, which was of some depth, was packed with absorbent cotton well powdered with persulphate of iron. The retractors were removed and the patient given an opiate. At no time, however, was the pain very great. The bowels were confined for five days; a purgative was then given, and the dressing came away with the action. The rectum was syringed daily, with equal parts of water and listerine, until the wound was entirely healed, all the discharge ceasing. Up to this date, four years after the operation, no disposition to return has been noticed. A section of the tumor was examined under the microscope and pronounced epithelioma.

CASE 2. I was sent for to go to an interior town to remove a pronounced cancer of the rectum from a man sixty-two years of age. I found, upon examination, that the growth began just above the sphincter muscle, but did not involve it. It extended at least two inches up the gut, involving at least two-thirds of its circumference. The prostate gland was not affected. The cachexia was plainly discernable and the neighboring glands enlarged. Although I told him that I could not promise any thing, he insisted upon the removal of the growth, which was now blocking the bowel to an appreciable degree. He was prepared for the operation, and, with the assistance of four physicians, it was done after the following manner: The patient was anesthetized; a free dorsal incision was made down to the sacrum, coming out at and over the coccyx, keeping as near the median line as possible. A slip of the knife cut the middle hemorrhoidal artery; considerable difficulty was experienced in securing it. The levator ani muscles were then carefully dissected up. It was found that the attachments and infiltration of tissue was very great, and the operation was necessarily done very slowly. The vessels were secured as the operation proceeded, and the entire growth was removed. It was impossible to bring the gut down and attach below, as advised by so many—which procedure, however, I could never get my consent to advocate. The sutures in these cases do much damage, and the accumulation of pus is, of course, to be expected. The stitches give way, and the result is not as favorable as when the wound is left open and so dressed. The whole space of excision was packed with carbolized cotton, a T bandage applied, and the patient given opiates sufficient to quiet pain. He was cared for by the local physicians, who, at the end of two months, reported the whole surface healed and the patient in a much more comfortable condition. Bowels moved freely and with but little pain. Up to this writing no return is noticed. A section of the tumor was submitted to Professor Dudley S. Reynolds, who examined it under the microscope and pronounced it epithelioma.

OPERATIONS UPON THE RECTUM UNDER WHISKY.

Perhaps the most painful of all surgical diseases is fissure of the anus, or irritable ulcer of the rectum. For its cure two operations are recommended, viz., divulsion of the sphincters, and division with the knife. Either of these is a most painful operation, and can not be done without chloroform. There are many patients averse to taking an anesthetic, and in many cases the surgeon is averse to giving it. Meeting in my practice such cases, and recognizing that an operation was imperative, I have operated a number of times by administering whisky in lieu of chloroform. Such procedure has been limited to fissure and irritable ulcers of the rectum; but, of course, it could be practiced in any affection calling for surgical treatment where an anesthetic was necessary. It is not the purpose of this paper to discuss the moral involved, if there be any, but suffice to say that I believe that no love for liquor or its effects would be induced, but the contrary might obtain.

The manner of administration that I have

practiced is, viz: Get the very best article of whisky possible. Begin by giving on an empty stomach one or two ounces, and repeat every twenty minutes until the full effect is obtained, as is evidenced in the drowsy, sleepy condition of the patient. My experience is that it takes from eight to twelve ounces to get this effect in the adult male. Of course habit in taking engenders a capacity for large amounts, and with this agent, as with many drugs, an idiosyncrasy may exist, which must be ascertained. Women are affected much more quickly and with less quantity than men, and children require but little whisky to get full effect. The same can be said of the aged.

CASE 1. Judge X., of Indiana, came to me for the treatment of a very irritable ulcer of the rectum, which was encroaching on the external sphincter muscle. For months, as he expressed it, his life had been a torture. He had cultivated a constipated habit, preferring this to the suffering that he experienced at each movement of the bowels. He objected to taking chloroform for the reason that he had been told that he had heart trouble. Although assured, after a careful examination of his heart, that he had no such trouble, he was persistent in his refusal to take an anesthetic. He was in splendid health, excepting this local trouble. I suggested to him the whisky plan, to which he assented. He went to his hotel and took the whisky according to directions until he had taken one pint in one hour. I visited him and did the operation by divulsion of the sphincters, and dividing the same with the knife in addition. Being called away that hight, I did not see him again for three days, at the expiration of which time I saw him in the rotunda of his hotel, and he told me that he did not remember a thing of the operation, and really did not know that I had been there until informed of the fact.

CASE 2. Dr. H. had suffered from an irritable ulceration of the rectum for a year or more. In consequence he had abandoned his practice. Had feared the operation for the cure of his condition, because he was sure of some heart affection. He consulted me, and an examination revealed the condition that he suspected. I advised him to substitute whisky for chloroform and have the operation done. He consented, and I went to his home, sixty miles away, and did the operation. When I reached him he was "dead drunk," according to directions, and divulsion was freely made, with the patient not evincing by the least sign that he suffered any pain. He afterward told me that he remembered absolutely nothing of the operation.

In this connection I desire to state that the anesthesia necessary to divulse the sphincters in an irritable condition must be more profound than that which would be necessary to extract a cataract. This has been the observation of both Dr. Reynolds and Dr. Coomes, who have given chloroform for me in these operations. Hence it is that I regard this, one of the most painful of all surgical operations; and if whisky would answer in these, it would in major operations of surgery, especially those requiring a long time for their performance, as the effect of the agent does not soon wear off. I cite only two cases, but I have used the method in a number, and always with good result. I do not believe it advisable to use it save in those cases where for sufficient reasons the surgeon declines to use the usual anesthetics, but I do believe that in these excepted cases it will be found an excellent *substitute*.

THE SPHINCTER MUSCLES IN DISEASE.

After an experience of a score of years in rectal surgery I am more and more impressed with the importance of the part played by the sphincter muscles in disease, not only in local manifestations, but in producing obscure symptoms which oftentimes lead the physician into a false diagnosis. I desire to recite a few cases that go to prove his assertion, and add that they are but at sample of many that have fallen under my observation.

CASE 1. Mr. H. G. came to me, accompanied by his physician, from a distant town in the South. The following history was elicited: About four years before he began to suffer with "cramps" in the abdomen. No special attention was paid to this, nor were they at that time associated with any rectal affection. Later on the patient complained of decided dyspeptic symptoms and an aching sensation around the anus. This sensation was not particularly referable to his stools, but was more or less vacillating as to time. Eventually pain was complained of as radiating over the sacrum and lumbar region and down the thighs. Whether imaginative or not, it was thought by the patient that his trouble was aggravated by eating, even of the most digestible diet. In consequence of this his physician enjoined an abstemious diet, and upon this he was kept for several years. Notwithstanding all treatment he grew gradually worse, until his physician suspected malignant growth. During the interim he was sent to different watering places and to the sea coast, but to no avail. He began to lose flesh rapidly, and at the time that I first saw him had lost about forty pounds. I examined him carefully for rectal trouble, but could not find a trace, except that the sphincter grasped my finger tightly upon its insertion, but the patient complained of no pain. I advised that a second examination be made, under chloroform, adding that I would attend to any trouble that might exist while he was under the anesthetic. Having the assistance of two physicians, he was chloroformed, and with different speculums I examined the rectum, but no disease was found. Acting upon the idea that his complaint was a nervous one, I divulsed the sphincters forcibly, nothing more. The result was that ever after he ate what he pleased and complained of no more pain. He has gained flesh ever since, and to-day weighs two hundred pounds, a gain of forty.

CASE 2. Miss B. was sent to me for treatment by her physician. She was accompanied by her mother, who gave a detailed statement of her daughter's condition. From the fact that she gave such an accurate description of a painful dysmenorrhea, and believing that the uneasy sensation about the anus was reflex, I suggested that she consult a gynecologist. This she did; and he informed me that, in his opinion, the trouble originated and was kept up by a displaced womb. For this he had her wear a supporter and take medicines prescribed. This treatment was followed with great care for many months, but without the least benefit. She believed that her trouble was in the rectum. Seeing that she placed great stress upon this, I got her to consent to take chloroform, and allow me to do whatever was necessary. To this she readily consented. Chloroform was given; no rectal disease was found, but the sphincters were forcibly dilated. She left the infirmary in one week. After three weeks her physician wrote me, saying: "Miss B. is a changed girl; she no longer complains of anything, and is now continually on the go, where, before this, she would not venture out of the house. What did you do?"

The recitation of these two cases I think quite sufficient to explain that in these obscure rectal cases, with symptoms that are vague and point to other trouble, an investigation of the sphincter should be made. That which evidences that it is the source of trouble is its irritability, with or without pain, upon examination.

As a factor in producing and keeping up a constipated habit, I am sure that this state of the sphincter muscles is the greatest of all causes. The late Dr. Cowling recognized this fact, and said to me, just before his death, that he believed that stretching the muscles would do much in overcoming constipation. In all cases where it has been necessary to divulse in rectal diseases, when constipation was co-existent, it has been my observation that said habit was overcome. Acting upon Dr. Cowling's suggestion, and the result as stated in these cases, I have quite often divulsed the sphincter ani muscles for long-continued constipation, always with most

excellent results. Recognizing the vast amount of trouble that constipation breeds, and knowing the difficulty that is generally met in overcoming the habit, I would respectfully advise the divulsion of the sphincters as a most excellent method of cure.

A NEW OPERATION FOR FISTULA IN ANO.

Many operations have been devised for the cure of fistula in ano, all of which have had as their chief aim the substitution of some remedy more pleasant than the knife; hence, we have the elastic ligature, the inelastic ligature, injections, etc., all of which have served some good purpose, but none of which have succeeded in supplanting the knife in all cases. Very much can be said in favor of each method, but certain it is that their employment is restricted to exceptional cases. Injections are of but little avail in old standing cases, for the reason that the membrane lining the sinus is of such thickness and composition that it resists medication. If the healing process is established at all it is at the external orific only, and this is not desirable.

When the ligature is used, either the elastic or non-elastic, the top portion only of the fistula is divided, leaving the bottom untouched, hence deviating from a rule in surgery which is imperative, viz.: "Fistulous sinuess must heal from the bottom." It was to obviate this difficulty that I devised the method which I shall describe briefly. The plan is this: Taking the ordinary exploring probe, it is inserted into the external orifice of the fistula to determine, if possible, that only one sinus exists. Fortunately the majority of fistulæ are of this kind. Being satisfied of this fact, I then take a long, slender laminaria tent and push it gently into the fistulous sinus to the fullest extent that it will go. This is allowed to remain for several hours, keeping the patient under observation during the interim, at the end of which time it is withdrawn. The procedure causes but little if any pain. The laminaria tent is preferable to sponge, for the reason that it furnishes its own moisture, which assists in its withdrawal. After this dilatation, I take Otis' improved *urethrotome*, with small point; closing the instrument tightly, it is pushed gently as far into the sinus as it will go, and then, by the aid of the screw attachment, dilate the sinus. When this is done, the turning of the screw at the side of the instrument will cause the concealed knife to protrude at the distal end according to the measurement desired. The instrument is then carefully withdrawn, cutting through the *wall* of the sinus throughout its whole length. The cut, as will be perceived, has been made subcutaneously, and the pain is insignificant. What hemorrhage takes place is easily controlled by pressure. In several instances I have turned the instrument and reinserted, practicing the same procedure upon the opposite side, at one sitting. If this is not thought advisable, the patient is allowed to go for several days before repeating the operation, which is to include the other side. The advantages that I claim for the operation are, viz.: Over the injection plan it must take precedence for the reason, as above stated, that the injection of any agent that is commonly used for such purpose does not accomplish what is desired. The sinus is lined by a thick pyogenic membrane which will, in many cases, resist the action of said agents; hence it is impossible to get healthy granulations. With this instrument both the top and the bottom on each side, if necessary, can be *cut through*, thereby insuring a good granulating surface, and this, too, without pain. Over the ligature, either elastic or non-elastic, it possesses the advantage of cutting through both top and bottom, or each side of this thick membranous sinus, while the ligature can not possibly go through any portion but the top of the sinus, as it cuts its way out, leaving, of course, the callous bottom, which in many cases would refuse to heal, it being a positive rule in surgery in the operation for fistula, established by Mr. Salmon, that the *bottom* of all these tracts must be divided to insure a cure. Again, in using the ligature

the sphincter muscle or muscles must of necessity be cut through by the ligature, if the internal opening be above them. In the operation with the instrument, the muscle is not divided or interfered with. Over the knife it can be claimed, (1) that this operation dissipates all horror in those patients that dread the knife; (2) that excessive hemorrhage is avoided; (3) the sphincter muscles are not cut; (4) the patient is not confined to bed or taken from business.

In the majority of cases which I have treated by this method, I have done so without them knowing that anything in the nature of an operation had been done. Exhibiting the instrument to them, the knife being concealed in its case, they have never known other than that it was a probe. If I find, after waiting a few days, that a sufficient depth was not reached, the instrument is again inserted and the same procedure practiced. The patient is kept under observation a sufficient length of time to be assured of a perfect cure. Where pus cavities are found, or many sinuses exist, of course this operation is not advised, but in the selected cases mentioned I am sure that the advantages claimed for it will be realized. A score of cases in my practice attest its value.

HÆMORRHOIDS.

There is nothing specially new in the treatment of hæmorrhoids. The same views as expressed in my report to this society in 1877 in regard to the injection of piles with carbolic acid (which report Mr. Allingham, of London, has done me the compliment of embodying and indorsing in his last work on Diseases of the Rectum), I still maintain to be correct, viz.: that the plan is painful, inefficient, dangerous, and does not effect, as Mr. Allingham says, a *permanent* cure. By said method patients are of necessity kept under observation and treatment for an indefinite length of time. By the plans of treatment as advocated by all scientific surgeons, patients with piles are radically cured in comparatively a few days, with no danger, and by proper manipulation with but little pain. It is the rarest thing that I keep patients under observation longer than ten days. My plan is to adopt the method best suited to each individual case. It is very seldom that my patients lose more than a few days from business, and the cure is radical. This can not be said of the injection plan. Where there is such unanimity of opinion among authors in regard to this matter, the wonder is that any man of scientific attainments should indiscriminately use injections of acid into well-formed tumors. If used at all, let it be in the small, bleeding capillary piles.

Before closing my report let me impress that there is no surgical patient but needs the most careful supervision in the treatment of his case. It may appear a simple thing to ligate a pile or lay open a fistula, but the after treatment in regard to hygiene, sepses, drainage, etc., is just as important as in the cases of the major operations in surgery.

Compliments of

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PRACTICE LIMITED TO

DISEASES OF THE RECTUM.